The Linacre Quarterly

Volume 74 | Number 3 Article 7

August 2007

Linacre Institute Paper: Catholic Medical Decision-Making On the Concept of Futility

Catholic Medical Association

Catholic Medical Decision-Making On the Concept of Futility

The understanding that some disease states were incurable and beyond effective therapy was originally propounded by Hippocrates who in his writings[1] advised his contemporaries to decline "to treat those who are overmastered by their disease realizing that in such cases medicine is powerless." As a result of continuing medical progress there is the realization that some diseases, which "overmastered" patients in the past, are now treatable and even curable. The dramatic achievements of modem medicine have lent an aura of omnipotence and hubris to therapeutics, which have given rise to a concept of "futility" in the vernacular of bioethics. This acknowledges the capacity of modern medicine to extend a kind of "survival" to patients who are beyond effective therapy. The realization that some life support actually comprises the prolongation of the dying process has led various medical organizations to attempt to define and circumscribe "futility" both as a theoretical concept and as a basis for bedside decision-making. Although there appears to be an intuitive consensus among bioethicists that there is a conceptual reality of the term "futility", there is, at the time a widespread conviction that its definition is ephemeral and lacking in universal application.[2]

The AMA Council on Ethical and Judicial Affairs in its comprehensive report on *Medical Futility in End of Life Care*[3] concluded, "Since definitions of futile care are value-laden, universal consensus on futile care is unlikely to be achieved." In clinical practice, controversy arises when the patient or proxy and the physician have discrepant values or goals of care. Typically, futility may be claimed when one party (e.g. the patient or proxy) wants to pursue the goal of preserving life in the absence of any hope of future improvement while the adversarial party sees dying as inevitable and wishes to define futility in terms that prescind from personal value judgments. Schneiderman, for example, has suggested that an intervention that is effective in less than 1% of cases should be considered futile.[6] The problem with using physiological criteria as the basis for futility is fraught with problems, however. The controversy in the so-called Baby Doe cases, for example, was based on the notion that preserving functions in otherwise impaired patients such as Down

syndrome infants could be contraindicated. Similarly, debates regarding the usefulness of neonatal intensive care of very low birth rate infants are often based not on survival rates alone but rather by an outcome of "intact survivors." An intervention in such cases may be judged as "futile" if the survival of the infant carries the risk of handicaps, which are considered inimical to a certain quality of life.

The resolution of disagreements about futility should preferably be based on what is in the best interest of the patient. Introduction of a desire to conserve limited resources of an institution or the society at-large may be of importance to health care planners or public health authorities but should not be introduced as the trump card in individual cases.

The Definition of Futility

The difficulty if not the impossibility of defining futility is derivative of the fact that such a definition would inevitably be subjective rather than objective. Judgments as to the effectiveness, value and purpose of medical treatment will unavoidably be based on value judgments regarding medical effectiveness. In addition, however, the intensity of the personal relationship of near relatives and surrogates to the patient at issue enters the equation. Attempts have been made to resolve controversies by decisions to pursue only the goal of comfort care. The physician in such a conflict situation provides life support in spite of his conviction that the only expectation is the prolonging of the dying process. It is also possible that the roles might be reversed; that is that the proxy may believe that the physician is inappropriately pursuing life prolongation when death is inevitable.

Conflicts regarding the appropriate intervention in a particular case may be further exacerbated by disagreements over which party has the decision-making authority. Such disagreements are best reconciled within the health care facility but in extreme cases may be referred to the courts for adjudication. Such precedents as exist in cases of irreconcilable disagreement as to which decision maker prevails are themselves conflicted.

One well-known case is that of Helga Wanglie in which a hospital went to court to seek permission to discontinue treatment they had judged to be inappropriate.[4] The patient's husband however, successfully asserted that his substituted judgment should take precedence over the hospital's view that intervention was not beneficial. The outcome of the Wanglie case indicates a hierarchy of authority in medical decision-making in which the decision of the patient or health care proxy takes precedence over presumed expertise of the health care team.

On the other hand, the ruling in *Gilgunn v. Massachusetts General Hospital* upheld the prerogative of the attending physician to decline to carry out intervention he judged to be futile.[5] The ambivalence of the courts in these two cases reinforces the preferential option of resolving conflicts without recourse to the courts. This institutional option is best served by an existing hospital policy on futility, which can be the basis for negotiation of impasses. Such policies also help to reduce public criticism of what can be seen as a paternalistic attempt by professionals to impose standards on patients.

One standard for judging an intervention to be futile would be that it has the intention of prolonging dying.

The principles proposed by O'Donnell[8] are relevant in this context. While the Catholic Church affirms the dignity of every human life, the Church also affirms faith in the resurrection, which enables Catholic tradition to accept death as the inevitable end to temporal life and a gateway to eternal life. It is for this reason that there is no obligation to utilize all possible remedies and all possible means of prolonging life. Since biological life is not an absolute value, death need not be avoided at all costs. Suicide, assisted suicide and euthanasia are opposed because they are intrinsically opposed to a reverence for life. Compassion and care for the dying must never include the willingness to assist in direct killing nor does it obligate to preserve biological life at all costs. It is not suicide or euthanasia to choose not to use or to bring to an end useless or disproportionately burdensome (ethically extraordinary) medical treatments, procedures or interventions. There is no "right to die" except as an inherent human right to be free from inappropriate interferences with one's dying process.

The final decision as to whether to withhold or withdraw medical treatment must not be an occasion for neglecting the patient. All normal care such as bed rest, hygiene, pain medication comfort and, most specifically, food and drink must be provided. As defined by John Paul II[8] this includes assisted nutrition in the category of ordinary care. The proposal that a community or locale might determine its own standards for what interventions will be provided carries particular risks for the Catholic community. The much discussed Oregon plan for allocating Medicare funds seeks to reflect community values in allocating Medicare funds. This system ranks various health care goals with the ultimate goal of rationing or, at least prioritizing health care resources. Futility-based arguments may have the same goals without making them explicit. Statistically, the number of cases involving futility debate has not been demonstrated to constitute a sufficient number of cases to challenge the availability of scarce resources or to be an effective strategy for conserving such resources on a community-wide scale.

Highly publicized cases such as Karen Quinlan, Nancy Cruzan and Terry Schiavo illustrate how Catholic views on the care of individuals in a persistent vegetative state could generate conflict between so-called community consensus and Catholic moral teachings.

Both the Hastings Center Guidelines[10] and the Consensus Report of the Society for Critical Care Medicine[11] propose policies, which would be questionable for Catholic health care institutions. It would be incumbent on Catholic communities such as sponsorship groups to develop independent guidelines, which might be swallowed up in so-called community consensus groups.

Process for Resolution of "Futility" Cases

1) Deliberation and Dialogue. Any policy for resolution of impasse would presuppose an open discussion between patients, proxies and physicians. Prognosis should be honestly and openly revealed and based on outcomes date whenever possible. Arriving at a joint position as early as possible in the progression of serious or fatal diseases so that goals for mutual understanding can precede inflexible partisanship.

2) Consultants and patient advocates should be invited into the process by mutual consent. Such "third parties" can frequently facilitate the discussion and give it a balance particularly where proxies may feel victimized by the system.

3) Ethics committees, which are already in place, should be consulted so that there is an aura of pursuit of standing policy rather than ad hoc assertion of prerogatives.

4) If the differences remain irreconcilable after a process of negotiation which both sides consider to have been impartial by professional standards,[2] arrangement for transfer to another institution may be sought. This can be a wholly unsatisfactory resolution since the ethical dilemma is not "solved" by moving it to another location.

5) In the not unlikely possibility that no alternative institution can be found, neither the physician nor the patient can be compelled to violate strongly held principles or ethical standards. Recourse to legal adjudication may be the only alternative albeit an undesirable and unsatisfactory conclusion as mentioned, legal precedents hold no guarantee as to how the courts will decide. Either the patient's autonomy or the physician's adherence to personal medical ethics and professional standards will be at risk in an outcome of legal adversarial decision-making.

6) The intrusion of the state into the process such as in the passage of the Texas Advance Directives Acs of 1999[13] would seem to have exacerbated rather than improved the issue as well as the frequency of resort to litigiousness and dissatisfaction with outcomes.[14]

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